INTERAGENCY RELEASE OF INFORMATION OR AUTHORIZATION

(Participant's Name – First, Middle Initial, Last) (Date of Birth) (Social Security Number)

I authorize information about the above referenced participant to be exchanged between the following System of Care User Group agencies or programs as listed below (initial all that apply):

- ☐ CASA – Court Appointed Special Advocate
- ☐ Child Care Connections
- ☐ Child Care Response Team
- ☐ Colorado Child Care Assistance Program (CCCAP)
- ☐ Community Partnership for Child Development
- ☐ Court: ____________
- ☐ Dept. of Human Services Program(s): ________
- ☐ Educational Program/School District: ________
- ☐ EPC Dept. of Health & Environment Program(s)
- ☐ Faith Partners: ____________
- ☐ Financial: ____________
- ☐ GAL – Guardian ad Litem
- ☐ Health Care: ____________
- ☐ Healthcare for Children with Special Needs (HCP)
- ☐ Hospital: ____________
- ☐ Military Program:
- ☐ Pikes Peak Family Connections
- ☐ AspenPointe Health Services
- ☐ Private Behavioral Health Therapist: ________
- ☐ Project BLOOM
- ☐ Resources for Young Children & Families (Part C)
- ☐ Social Security Service
- ☐ TESSA (Domestic Violence Prevention)
- ☐ The Resource Exchange (TRE)
- ☐ WIC – Women Infants and Children
- ☒ Other: ____________
- ☒ Other: ____________

(Boxes in this section checked off by staff member)

I understand that information disclosed may be written, verbal or electronic form and may include date(s) of contact, locations and reasons for contact, symptoms presented, treatment progress, outcome information, prescriptions, written referrals, educational records, tests performed, and/or diagnosis. I understand that disclosure may include: psychological/psychiatric; medical; shelter and case management; and/or alcoholism, drug and/or alcohol abuse information.

I understand that the purpose of this information disclosure is to allow the participating entities (identified above) to access and use the information to establish and maintain continuity of care, better assess the effectiveness of the program, and/or to improve their services based on service utilization studies.

I understand that I may refuse to sign this authorization, and no one is conditioning treatment, payment, enrollment or eligibility for benefits on signing this authorization. However, the System of Care User Group can condition those things if, (1) the treatment is research-related and the authorization is needed to use or disclose protected health information for such research [this form has been so conditioned ☐], or (2) for services conducted solely to produce information for a third party and the authorization is for the disclosure of the protected health information to that third party [this form has been so conditioned ☐]. This form has not been conditioned unless one of these has been checked by staff.

I understand that there is potential for information disclosed, as a result of this authorization, to be redisclosed by the recipient and therefore no longer protected by the HIPAA Privacy Regulations. When applicable, an assessment of the minimum necessary amount of information required has been applied to this authorization.

I understand that I may revoke this authorization, at any time, by giving written notice to the authorized System of Care User Group agencies or programs, except to the extent that action has already been taken to comply with it. Without such revocation this authorization will expire on , or if left blank, one year from my signature date, or as of the action/event of

____ .

I understand that I am entitled to a copy of this authorization.

Signature of Participant/Authorized Guardian/Legal Representative	Authority to act on Participant's behalf	Date

I hereby revoke this Authorization to Disclose Information.

Signature of Participant/Authorized Guardian/Legal Representative	Authority to act on Participant's behalf	Date

Notice to whom this information is given: This information has been disclosed to you from records that may be protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

 A copy/facsimile of this authorization is as valid as the original [ ] Original [ ] Revised (Date ___/___/___)

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A copy/facsimile of this authorization is as valid as the original [ ] Original [ ] Revised